OFFICE OF EMERGENCY MEDICAL SERVICES

APPLICATION FOR TEMPORARY 90-DAY WAIVER OF EMT CERTIFICATION REQUIREMENTS

Refer to OEMS Administrative Requirement (A/R 5-201) for further information relative to this waiver application. All information must be typed or printed legibly.

_____
Ambulance Service Number

_____ _____
Ambulance Service Name Owner or Chief Officer

_____ _____
Street Address or P.O. Box Title

_____ _____ _____
City/Town/State Zip Code Telephone

JUSTIFICATION FOR WAIVER: Explanation as to why the public convenience and necessity require such a waiver (attach any additional documentation as appropriate):

INDIVIDUAL TO BE COVERED BY THIS WAIVER:_____

STREET ADDRESS OR P.O.BOX:_____

CITY/TOWN: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

1. Has an ambulance service ever been issued a temporary waiver for this individual before?

   _____ No _____ Yes, date _____

2. Has the individual submitted an application for Massachusetts EMT-B certification exam? (This is a prerequisite for waiver approval.)

   _____ No _____ Yes, date _____

3. Indicate basis for waiver eligibility (either A or B.):

   A. ☐ Individual has completed a Department approved EMT course.

      Course location and completion date: _____

   B. ☐ Individuals EMT-B certification has expired, but individual is an approved candidate for reinstatement. Examination. Attach proof of completion of applicable refresher course.

AMBULANCE SERVICE:
I request this waiver on behalf of the ambulance service and I fully understand the requirements and conditions of such a waiver, and accept full responsibility for orienting and overseeing/monitoring/evaluating the specifically named EMT-B candidate's work for the duration of the waiver period. I understand that this waiver is valid for 90 days, and is not renewable.

Signature _____

Date_____

INDIVIDUAL TO BE COVERED BY THIS WAIVER:
I concur with this request by the ambulance service and I fully understand the requirements and conditions of such a waiver.

Signature _____

Date_____

Attach current, legible copies of driver's license, and both sides of CPR card, (American Heart Assoc. level-C provider or Red Cross professional rescuer, or National Safety Council "Health Care Provider")

For office use only:

_____ _____
Effective Date Expiration Date